

**STATE OF DELAWARE
WORKPLACE SAFETY PROGRAM QUESTIONNAIRE**

GENERAL INFORMATION --TYPE OR PRINT CLEARLY

Provide All Requested Information

Business Name:_____

Street Address:_____

City/Town:_____ Zip:_____ Telephone #:_____

Person and Title Completing Form:_____ Date:_____

Contact Person and Title:_____

(If different than person completing form)

Type of Business:_____

Describe Operation:_____

List All Locations or Sites Covered By Policy:_____

DEPARTMENT USE ONLY

RENEWAL DATE:_____ FILE #_____ # OF YEARS:_____ PROOF PAGE:_____

DUE DATE:_____ CHECK#_____ AMOUNT:_____

LOCATION (S):_____ INSPECTION (S):_____

COMMENTS:_____

DELAWARE EMPLOYER'S WORKPLACE HEALTH AND SAFETY INCENTIVE PROGRAM

GENERAL QUESTIONNAIRE

I. SAFETY PHILOSOPHY

- | | | |
|--|-----|--------|
| 1. Do you adequately train and supervise your employees? | Yes | No |
| 2. Do supervisors set a good example for you employees? | Yes | No |
| 3. Are safety rules enforced at all levels? | Yes | No |
| 4. Do you monitor the use and condition of protective equipment? | Yes | No |
| 5. Do you practice consistent good housekeeping? | Yes | No |
| 6. Do you perform periodic preventive maintenance? | Yes | No |
| 7. Is all mechanical equipment inspected regularly? | Yes | No |
| a) Are all mechanical defects corrected before equipment is reused? | Yes | No |
| b) Is old or substandard equipment replaced? | Yes | No |
| 8. Are you willing, and do you spend money on a regular basis to create a safer work environment? | Yes | No |
| 9. Do you have a complete safety program, with a written Policy Statement? | Yes | No |
| Attach a copy. | | |
| a) Do you have a Safety Coordinator or someone designated to do that function? | Yes | No |
| b) Do you follow OSHA record keeping procedures? | Yes | No N/A |
| c) Are all accidents reviewed to determine the underlying cause, and do you eliminate hazards related to/causing the accident? | Yes | No |
| d) Do you conduct periodic safety inspections? | Yes | No |
| e) Are unsafe conditions improved where and when needed? | Yes | No |
| f) Are accidents promptly reported to you? | Yes | No |
| g) Do you have written emergency plans? | Yes | No |

II. SAFETY PROMOTIONS

- | | | |
|--|-----|----|
| 1. Do you have a safety committee? | Yes | No |
| 2. Do you have periodic meetings on safety topics? | Yes | No |
| 3. Do you use safety posters: changed frequently? | Yes | No |
| 4. Do you have a safety suggestion box? | Yes | No |
| 5. Do you partially or fully subsidize the employees for their protective equipment? | Yes | No |

III. EMPLOYEE SELECTION AND TRAINING

- | | | |
|---|-----|----|
| 1. Does job training begin before work actually starts? | Yes | No |
| a) Does it cover job rules, use of equipment, job hazards, general company safety rules, methods for reporting accidents and unsafe conditions? | Yes | No |
| 2. After an employee starts work: | | |
| a) Are all workers supervised on the job, especially the newer & less experienced? | Yes | No |
| b) Do you get the cooperation of the older, more experienced employee? | Yes | No |
| c) Do you enforce the use of protective equipment? | Yes | No |
| d) Do you give periodic refresher courses on equipment use and safety rules? | Yes | No |

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|---|-----|----|
| e) Do you make safety manuals and pamphlets available? | Yes | No |
| f) Have you put up warning poster in strategic locations? | Yes | No |

IV. EYE PROTECTION

N/A

You should complete this section whenever employees are exposed to such hazards as chemical fumes, vapors, splashes, intense heat, molten metals, wood and metal chips; high dust levels.

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|--|-----|----|
| 1. Are safety glasses worn which meet or exceed ANSI standards? | Yes | No |
| a) Do they have side shields? | Yes | No |
| b) Are goggles worn when they are needed? | Yes | No |
| c) Are all glasses regularly cleaned after each use, particularly the goggles? | Yes | No |
| 2. Are safety shields worn? | Yes | No |
| a) Over safety glasses? (for protection against chemical splash, glass breakage & severe impact hazards) | Yes | No |
| 3. Are there eye or eye/face wash stations in areas where chemicals are handled? | Yes | No |

V. FIRST AID

- | | | |
|--|-----|--------|
| 1. Are medical personnel readily available or on call? | Yes | No |
| 2. Are emergency phone numbers posted in prominent places? | Yes | No |
| 3. Do you have physician-approved first aid supplies: highly visible & close to employees; inspected and replenished continuously? | Yes | No |
| 4. Do you have shower facilities? | Yes | No N/A |
| 5. Is there at least 1 worker or supervisor on each shift who has been technically trained and is competent and responsible for administering first aid treatment? | Yes | No |
| 6. Do you keep records of all injuries and illnesses? | Yes | No |

VI. HEARING PROTECTION

N/A

Complete this section if your business has a DBA level of 85 or more.

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|---|-----|----|
| 1. Do you have a hearing conservation program? | Yes | No |
| a) Do you comply with all OSHA or Delaware state standards where employees are exposed on a regular basis to high noise levels? | Yes | No |
| b) Are workplace noise levels monitored? | Yes | No |
| c) Do you give your employees annual hearing tests, with records maintained? | Yes | No |
| c) Is proper hearing protection (ear muffs or plugs) furnished and/or required To be worn? | Yes | No |
| e) Is this enforced? | Yes | No |
| f) Penalties for violation (describe)_____ | | |
| 2. Do you give employees periodic rest periods or alternate work away from the noise? | Yes | No |
| 3. Do you change worker or job schedules to cut down on noise exposure? | Yes | No |
| 4. Do you rotate or transfer personnel who show evidence of a significant shift in hearing threshold? | Yes | No |

VII. HOUSEKEEPING AND MAINTENANCE

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|--|-----|----|
| 1. Do you store items in passageways or on stairways or ramps? | Yes | No |
| 2. Are all work areas and aisles free of congestion? | Yes | No |

3. Any electrical cords strung across walkways?	Yes	No
a) If so, are they properly marked and guarded?	Yes	No
4. Do you have specific storage areas?	Yes	No
5. Are any loose floor mats safety-edged?	Yes	No
6. Any worn or frayed carpet, open carpet seams or curled edges?	Yes	No
7. Any holes, uncovered drains, protruding nails, splinters, loose boards or projections in floors?	Yes	No
8. Are there any false floors or platforms used to provide dry standing & walking surfaces?	Yes	No
9. Are all floors free of debris, lint, dust, oil, grease, paint or spray residue, granular materials, sand, mud, ice or other slippery traction-robbing material?	Yes	No
10. Is lighting adequate for all operations?	Yes	No
11. Is there a proper and functioning ventilation system?	Yes	No
12. Are all exits clearly marked and unobstructed?	Yes	No
13. Is there frequent pickup of refuse?	Yes	No

VIII. MACHINE GUARDING

N/A

Complete this section only where machinery is in use.

1. Do you have only trained individuals operating or repairing machinery?	Yes	No
2. Are proper guards installed on all moving parts of the machine?	Yes	No
3. Does someone regularly inspect the guards to see that they are still in use and mounted properly?	Yes	No
4. Are any defects remedied immediately?	Yes	No
5. Is corrective action taken against employees who remove guards or disengage safety devices?	Yes	No
6. Is the anchoring secure for fixed-location machinery?	Yes	No
7. Are lockout devices installed?	Yes	No
8. Are all circuits properly grounded?	Yes	No

IX. MATERIALS HANDLING

N/A

Complete this section if you have significant storage and materials handling exposures.

1. Do you do any pre-employment screening for employees with a history of back problems?	Yes	No
2. Do you give training in proper lifting procedures?	Yes	No
3. Re: Heavy materials handling controls:		
a) Are your employees trained in the use of equipment?	Yes	No
b) Is operation restricted to authorized employees only?	Yes	No
c) Are proper safeguards installed which protect the operators from contact with moving parts of the machinery or with the load?	Yes	No
d) Is the equipment on a preventive maintenance schedule?	Yes	No
e) Is all equipment inspected at the start of each shift?	Yes	No
f) Is the equipment always operated within its rated capacity?	Yes	No
g) Are there good housekeeping and stacking procedures in storage areas?	Yes	No

X. MEDICAL EVALUATION

Where allowable under State and Federal guidelines:

1. Is the physical exam job-exposure oriented?	Yes	No
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2. Does your examiner check for signs of drug or alcohol abuse?	Yes	No
3. Are pre-existing conditions noted and documented?	Yes	No
4. If respirators are worn, is there periodic pulmonary testing?	Yes	No
5. In noisy areas; is there periodic audiometric testing	Yes	No
6. Do you encourage your employees to report any symptoms of illness between physical checkups?	Yes	No

XI. PROTECTIVE CLOTHING AND EQUIPMENT **N/A**

This section deals with protective clothing necessary for the job or jobs performed.

1. Does clothing comply with applicable regulations and guidelines?	Yes	No
2. Is clothing well-designed and made of proper materials?	Yes	No
3. Is it well-fitting; covering all exposed areas of the body?	Yes	No
4. Is it appropriate to the work being performed?	Yes	No
5. Is clothing cleaned, maintained & inspected on a regular basis?	Yes	No
6. Are safety shoes appropriate or required?	Yes	No
a) If required, are they worn?	Yes	No
7. Are safety hats required?	Yes	No
a) If required, are they worn?	Yes	No

XII. RESPIRATORY PROTECTION **N/A**

This section applies if your business has an exposure to respiratory hazards.

1. Oxygen deficiency hazard?	Yes	No
2. Vapor and particulate hazards (dusts, sprays, fumes, mists, fogs, smoke or smog)?	Yes	No
3. Any gaseous contaminants?	Yes	No
4. Are work areas monitored regularly for contaminant levels?	Yes	No
5. Are respirators required to be used?	Yes	No
a) Are they properly fitted?	Yes	No
b) Are instructions given in proper use?	Yes	No
c) Are they cleaned, inspected and disinfected after each use?	Yes	No
d) Are filters replaced on a regular, routine basis?	Yes	No

XIII. SKIN PROTECTION **N/A**

This section applies if your business manufactures or uses irritation-producing substances.

1. Are employees with a current or prior work history of dermatitis identified and assigned to another job?	Yes	No
2. For workers working in skin disorder-producing environments:		
a) Are the least irritating substances possible used?	Yes	No
b) Is the process enclosed and separated from the worker?	Yes	No
c) Is there continual good housekeeping, including immediate cleanup of unavoidable spills ?	Yes	No
d) Is proper protective clothing and equipment worn?	Yes	No
e) Are water-soluble barrier creams used?	Yes	No
f) Are wash-up facilities (including showers in certain work) provided?	Yes	No

XIV. AUTOMOBILE **N/A**

This section applies if you have employees who drive cars or trucks as a regular part of their work; also where employees drive their own cars on company business.

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|---|-----|----|
| 1. Is a good attitude evident on the part of the drivers, their supervisors and the union (if you have one) concerning individual and corporate driver safety responsibilities? | Yes | No |
| a) Are scheduling & driving speeds reflective of this? | Yes | No |
| b) Are Motor Vehicle Reports (MVR's) requested on all drivers at regular intervals? | Yes | No |
| c) Are MVR's requested on all prospective employees, covering all states in which they have been licensed? | Yes | No |
| d) Are regular driver training and safety meetings held? | Yes | No |

How often? _____

2. What actions are taken in connection with accidents or violations, and have they proven effective?
Describe. _____

- | | | |
|--|-----|----|
| 3. Any time pressures inherent in your operations? | Yes | No |
| If "yes", describe. _____ | | |

XV. GENERAL INFORMATION

1. When did your insurance carrier last conduct an engineering & loss control inspection of your premises and operations. Date: _____

- 2.. What worker's compensation recommendations have been made by them?

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|----------------------------------|-----|----|
| 3. Have they been complied with? | Yes | No |
|----------------------------------|-----|----|

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|---|-----|----|
| 4. Has an OSHA inspection ever been done? | Yes | No |
|---|-----|----|

- | | | |
|---|-----|----|
| a) If so, were any recommendations made, citations issued; fines or penalties levied? | Yes | No |
|---|-----|----|

If "yes", explain.

5. What regulatory authorities inspect your operations?

a) How often? _____

Name of person completing this questionnaire: _____

Title: _____

Date: _____

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